MEDICAID MARYLAND MHA (PMHS)
PRE-ENROLLMENT INSTRUCTIONS – 77062

Medicaid Maryland PMHS is administered by Value Options.

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 1 week.

WHAT FORMS DO I NEED TO COMPLETE?

- You must complete the 2 forms listed below:
  - Online Provider Services Account Request Form
  - Online Provider Services Intermediary Authorization Form
- For ***Electronic Remittance Advice (835/ERAs)***
  - Value Options uses a service called PaySpan Health to deliver Electronic Remittance Advice.
  - If you wish to receive ERAs you must create an account (free) on https://www.payspanhealth.com/.

OFFICE ALLY CANNOT SUPPLY OR ACCESS THESE REPORTS.
YOU WILL NOT BE ABLE TO ACCESS YOUR ERAs THRU YOUR OFFICE ALLY ACCOUNT.

- For **Claim Status Reports**
  - Value Options refers to Claim Status Reports as a Summary Voucher.
  - In order to receive these summary vouchers you must create an account with Value Options.
    - Go to www.valueoptions.com.
    - Select the Provider Tab.
    - Select Register under Provider Connect login on the right hand side of the screen.
      - Call 888-247-9311 option 2 for help.
      - It is important to include your email address on this form since your password will be sent to this email address.

IF YOU DON'T CREATE THE ACCOUNT FOR CLAIM STATUS REPORTS YOU RISK HAVING A REJECTED CLAIM AND BEING UNAWARE OF IT. OFFICE ALLY HAS NO WAY OF ACCESSING/SUPPLYING THESE REPORTS.

WHERE SHOULD I SEND THE FORMS?

- The forms need to be faxed to Value Options at 866-698-6032

WHO CAN SIGN THE FORMS?

- The owner or other authorized personnel may sign the form

OBTAINING APPROVAL: HOW DO I CHECK STATUS?

- One week after faxing your form to Value Options, you must call Value Options at 888-247-9311 opt. 2 and ask if your account has been set up and linked to Office Ally.

NOTE TO MY CLIENTS PLUS USERS:

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally, please fax the following information to My Clients Plus at 888-653-7115.

- **My Clients Plus**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement "I have verified my provider ID has been linked to Office Ally with the Insurance Payor".**
- **Provider email address where you can be notified of setup completion.**

For Noridian Pre-Enrollments Please Also Include:

- **Submitter number**

Online Provider Services Account Request Form

Required fields are marked with an asterisk. * Fax pages 1 & 2 of completed form to 866-698-6032. Questions on this form? Read instructions on page 3.

Special Setup: (See page 3)
☐ Additional Login Account
☐ New Grouped Account
☐ Existing Grouped Account: ______________________

***Provider, Practice or Facility Name**

ValueOptions assigned Provider ID. If not known, please contact the correct provider contacts on page 3

***NATIONAL PROVIDER IDENTIFIER # (NPI)**

***Provider, Practice or Facility Tax ID (do not include the dash)**

***Address**

***City** | ***State** | ***Zip Code**

(____)____
***Telephone Number**

(______)____
Fax Number

***Please check which Online Provider Services options you would like to have access to:**

☐ Electronic Batch Claims Submission (Claim batch file uploads)
☐ Direct Claims Submission (Directly on website)

Automatically included:
☒ Eligibility Inquiry ☒ Claim Status Inquiry
☒ Authorization Inquiry & Submission

***Provider named above or office staff will be submitting claims** ☐ Yes ☐ No (N/A if only requesting inquiry status)

Provider has retained a 3rd party Billing Agent or Clearinghouse to submit claims on their behalf. (Other than office staff) (If yes, please complete the Billing Intermediary Authorization Form) ☐ Yes ☐ No

Depending on the state in which you are practicing, you may need multiple accounts created to ensure the claims are processed accurately (i.e. Medicaid vs. Commercial). Therefore, to help us in setting up your account(s) correctly, if you are located in…

Colorado, will you be submitting CO Medicaid clients?	☐ Yes ☐ No, Commercial Only ☐ Both
Illinois, will you be submitting Illinois Mental Health Collaborative or ICG clients?	☐ Yes ☐ No, Commercial Only ☐ Both
If yes, will you be submitting Batch Registration Files?	☐ Yes ☐ No
Kansas, will you be submitting either KS Medicaid Claims or AAPS Block Grant clients?	☐ Yes ☐ No, Commercial Only ☐ Both
Maryland, will you be submitting MD MHA clients?	☐ Yes ☐ No, Commercial Only ☐ Both
Massachusetts, will you be submitting MBHP clients?	☐ Yes ☐ No, Commercial Only ☐ Both
Pennsylvania, will you be submitting SWPA Medicaid clients?	☐ Yes ☐ No, Commercial Only ☐ Both
Pennsylvania, will you be submitting for the Non-HealthChoices Mental Health Program?	☐ Yes ☐ No Counties: ______________
Texas, will you be submitting TX NorthSTAR clients?	☐ Yes ☐ No, Commercial Only ☐ Both

_____________________________@____
*** Provider's Contact e-mail address – Please print**

_____________________________@____
E-mail address where you would like to receive your batch submission file feedback. - Please print.

***Contact Name at Provider's Office**

ValueOptions, Inc / EDI Helpdesk / PO Box 1287, Latham, NY 12110/Phone#: 888-247-9311

Forms that are incomplete, incorrect or illegible may delay or prevent proper processing.

Online Provider Services
Account Request Form

Required fields are marked with an asterisk. *
Fax pages 1 & 2 of completed form to 866-698-6032.
Questions on this form? Read instructions on page 3.

Agreement Terms:

A. **The undersigned submitter authorizes ValueOptions to receive and process claims or batch registration submissions via the ValueOptions Electronic Transport System (ETS) or ValueOptions Online Provider Services Program on his/her/its behalf in accordance with the applicable regulations.**

B. **All submitted information must be true, accurate and complete. I/We understand that payment of any claim submitted in falsification or concealment of a material fact may be prosecuted under any applicable state and/or federal laws.**

C. **The Submitter agrees to comply with any laws, rules and regulations governing the ValueOptions Online Provider Services/EDI program.**

D. **The Provider agrees to accept, as payment in full, the amounts paid in accordance with the fee schedules provided for under previously established agreements with ValueOptions.**

E. **This is to certify that an exact copy of any claim files submitted via the ValueOptions ETS system or Online Provider Services program will be stored in an electronic medium and held by the originator for a period of 90 days or until the submission has been finalized as to reimbursement or denial of payment, whichever comes first.**

***This is to certify that the following is true:**

_____I am a provider
OR
____I am office staff of a Provider, and am authorized to sign on their behalf.

Signatures:

______________________________	______________________________	
Legal name of Organization	**Title of individual signing for organization**	
______________________________	______________________________	__________
***Name of Individual Signing for Organization**	***Authorizing Signature**	***Date**

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Instructions for Account Request Form

The Account Request Form is only for activating online access on ValueOptions ProviderConnect website. If you need to update your service locations, mailing address, or tax information, you will need to contact our ProviderRelations area at 800-397-1630.

Additional Login Account?
If a ProviderConnect account already exists for the provider or facility, and an office staff member needs their own unique ID/password, you can check this box. If this secondary account needs to be disabled or deleted for any reason, it will be the provider's responsibility to contact the EDI Helpdesk immediately.

What is a Grouped Account?
- If you bill using several individual unique ValueOptions assigned provider numbers, we can set up a single login ID with access to multiple provider numbers. We will need a copy of this form for each provider, and you can check the appropriate box.
- If you bill as the facility using only a single provider ID, we only need one copy of this form. You will not need to check the "Grouped Account" box.

New Grouped Account:
Only check this box if you are registering multiple provider numbers, you want them accessible from a single user ID and password, and if you currently do not have a login ID for ProviderConnect.
Existing Grouped Account:
Only check this box if you currently have a grouped account login ID for ProviderConnect, and you want to include an additional provider number to be accessible from this account. Please write your existing login ID on the blank line. Make sure you put the new provider number in the appropriate field.

Provider ID number:
To make sure you have the correct provider ID numbers, and depending on what state and type of claims you will be submitting, the following service centers will be able to best assist you:

For all commercial accounts or states not listed below: 800-397-1630
Colorado Medicaid: 800-397-1630
Illinois Mental Health Collaborative or ICG: 800-397-1630
Kansas Medicaid or AAPS Block Grant: 800-397-1630
Maryland MHA: 800-888-1965
Massachusetts MBHP: 800-495-0086
Pennsylvania SWPA Medicaid or Non-HealthChoices Mental Health Program: 800-397-1630
Texas NorthSTAR: 800-397-1630

Batch vs. Single Claim Submission:
Single Claim Submission: If you are a smaller practice, or happen to have a low volume of Professional claims (normally submitted on a HCFA-1500 or CMS-1500), Single Claim Submission may be best and easiest. With this option, you can submit each claim directly on the website, the member and provider information are verified, and you receive a claim number right away.

Batch Claim Submission: If you have to submit Institutional claims (submitted on a UB-92 or UB-04 form), and/or if you have a larger volume of Professional Claims, you can select Batch Claim submission. With this feature, you will create your claims using either our EDI Claims Link Software, or your own practice management software. You will then upload a batch file via our website for processing. Claim numbers are usually available in about 1 business day.
You can select both Batch Claim and Single Claim Submission if you like.

Commercial and Medicaid Claims:
We may need to create more than one online account for you if you need to submit both commercial and Medicaid claims.
If you only select commercial or Medicaid for now, and you need to add the other in the future, please contact the EDI Helpdesk and we can make the appropriate updates for you. **If no option is checked, the default will be Commercial Only**.

If you have any further questions at this point, please call the EDI Helpdesk at 888-247-9311.

ValueOptions, Inc / EDI Helpdesk / PO Box 1287, Latham, NY 12110/Phone#: 888-247-9311
Forms that are incomplete, incorrect or illegible may delay or prevent proper processing.

Online Provider Services
Intermediary Authorization Form

Required fields are marked with an asterisk. *
Please fax completed form to 866-698-6032.
Questions on this form? Call 888-247-9311

INSTRUCTIONS:
This form should be completed by providers who contract with a third party to submit claims. If the Billing Intermediary will submit claims for multiple providers, an Account Request Form and an Intermediary Authorization Form is required for each provider. Forms that are incomplete, incorrect or illegible may delay or prevent proper processing.

Billing Agent/Clearinghouse/Intermediary Information

Office Ally, LLC
***Billing Intermediary Name**

OFFICEALMD
***Billing Intermediary's Submitter ID (if already established)**

Customer Service
***Contact name at billing intermediary**

support@officeally.com
***Email address at billing intermediary**

866-575-4120 option 1
***Phone number at intermediary**

Provider Information:

***Provider Name**

***Provider NPI number**

ValueOptions assigned provider ID number

*Please check those options for which you have been authorized by the below-signed provider.

☐ Electronic Claims Submission ☐ Single Claims Submission ☐ Online Eligibility Inquiry ☐ Online Claim Status Inquiry
☐ Authorization Inquiry

Agreement Terms:

A. The undersigned Provider authorizes the above Billing Intermediary to submit claims to ValueOptions on his/her/its behalf in accordance with any applicable regulations.
B. The provider warrants that he/she/it has entered into a written agreement with above named Billing Intermediary. The provider understands and agrees that its use of this Billing Intermediary does not in any manner relieve the provider of full responsibility and liability for any violations of the laws, regulations and rules which govern the ValueOptions EDI program.
C. The provider accepts full liability for all actions of the above named Billing Intermediary within its actual or apparent authority to act on behalf of the provider, notwithstanding any contrary provisions in the agreement between the provider and the Billing Intermediary. In the case of any violations of applicable laws, rules and regulations governing the ValueOptions EDI program, which arise out of the actions of the Billing Intermediary, the provider accepts full liability as though these actions were the provider's own actions.
D. The provider agrees to notify ValueOptions in writing at least ten (10) days prior to the effective date of the revocation of this Intermediary Authorization Form. In such event, the provider's liability for the acts of the Billing Intermediary will continue until the tenth day after the receipt of such notification or the effective date of the revocation, whichever is later.

Signatures: Brian O'Neill
***Billing Intermediary's Signature**

9/4/09
Date

***Provider or provider's staff signature**

Date